

EMS Agency Name:

Date of Inspection:

Agency No.

Approved ☐ Yes ☐ No

Follow Up ☐ Yes ☐ No

Rep Sign: _____



1041 Technology Park Drive
Glen Allen, VA 23059-4500
(800) 523-6019

APPLICATION FOR EMS AGENCY LICENSE

PLEASE COMPLETE APPLICATION FORM IN ITS ENTIRETY
PRIOR TO TIME OF INSPECTION. IF YOU HAVE QUESTIONS,
PLEASE CONTACT YOUR PROGRAM REPRESENTATIVE.

PLEASE COMPLETE ENTIRE APPLICATION

Agency Name: FIN #

Agency No.: NPS #

Physical location of agency and directions from major route:

Number of stations: (Please attach a list of each station number, name, complete address and phone number)

Mailing Address:

(Street Address)

(City, State, Zip Code)

Shipping Address:

(Street Address)

(City, State, Zip Code)

Agency Telephone No.: Fax:

Agency E-mail Address:

Agency FIPS No.: Agency Web site:

Type of Application:

Please Select the **Organizational Status** and **Type**, all **Classifications**, and **Description** of Agency

Organizational Status: Description:

Organizational Type: If Other describe:

Classification:

☐ Non-Transport - BLS

☐ Emergency Ground Transport - BLS

☐ Neonatal Ambulance

☐ Non-Transport - ALS

☐ Emergency Ground Transport - ALS

☐ Air Ambulance

Does agency utilize career EMS Personnel?

If so, who are they employed by:

Types and no. of personnel:	<input type="text"/>	First Responder	<input type="text"/>	EMT-Paramedic
	<input type="text"/>	EMT-Basic	<input type="text"/>	Driver Only (EVOC)
	<input type="text"/>	EMT-Enhanced	<input type="text"/>	Support Personnel
	<input type="text"/>	EMT-Intermediate	<input type="text"/>	MD <input type="text"/> RN <input type="text"/>

Hours of Operation: ☐ 24 Hours ☐ Other

Month/Year agency established:

Month/Year agency began EMS operations:

Agency is a member of: ☐ Virginia Association of Volunteer Rescue Squads

☐ Virginia Ambulance Association

☐ Virginia Governmental EMS Administrators

EMS TRANSPORTS:

Total no. of 911 calls/calendar year:

EMS dispatch volume/calendar year:

EMS Transport volume/calendar year:

EMS contact volume/calendar year:

Total service area (square miles):

Total service area population:

Are agency vehicles used by any other licensed agency?

If yes, total number of calls other agencies utilize vehicles permitted to your EMS agency?

Vehicle insurer:

Underwriter

No. of defibrillators:

Manual

Policy Number

Automated

Expiration Date

Combination

AGENCY OFFICIAL REPRESENTATIVE(S) OR OWNER(S)**REPRESENTATIVE/OWNER #1:**

Name:

Title:

(Last, First, Middle)

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number:

Evening Phone Number:

E-mail Address:

SSN:

REPRESENTATIVE/OWNER #2:

Name:

Title:

(Last, First, Middle)

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number:

Evening Phone Number:

E-mail Address:

SSN:

VPHIB ADMINISTRATOR:

Name:

Title:

(Last, First, Middle)

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number:

Evening Phone Number:

E-mail Address:

AGENCY DESIGNATED INFECTION CONTROL OFFICER:Name:

(Last, First, Middle)

Title:

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number: Evening Phone Number: E-mail Address: **TRAINING OFFICER:**Name:

(Last, First, Middle)

Title:

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number: Evening Phone Number: E-mail Address: **OPERATIONAL MEDICAL DIRECTORS:**

1.
2.
3.

COMMUNICATIONS:Dispatch facilities: ☐ Agency ☐ Central Dispatch (Specify) ☐ Other (Specify) Dispatch business telephone number: **FREQUENCIES:**

Dispatch Frequencies:	1) TX	<input type="text"/>	PL	<input type="text"/>	RC	<input type="text"/>	PL	<input type="text"/>
Other Frequencies:	1) TX	<input type="text"/>	PL	<input type="text"/>	RC	<input type="text"/>	PL	<input type="text"/>
	2) TX	<input type="text"/>	PL	<input type="text"/>	RC	<input type="text"/>	PL	<input type="text"/>
	3) TX	<input type="text"/>	PL	<input type="text"/>	RC	<input type="text"/>	PL	<input type="text"/>

Agency notified by: Number of radios: Mobile Portables Paging Emergency telephone number: ☐ 911 ☐ Other Emergency telephone number listed for public: Does dispatch prioritize or provide pre-arrival instructions?: FCC license holder: ☐ Agency ☐ Local Government ☐ Other If local government or other, written permission for use?: FCC license expiration date:

EXTRICATION EQUIPMENT:

Is required equipment supplied by applicant agency?

If no, who is supplying the required equipment?

OTHER EQUIPMENT: (check all that apply)☐ Rescue/Crash Truck☐ Technical Rescue Vehicle/Trailer☐ Water Rescue Capability☐ Disaster/Mass Casualty Trailer☐ Haz Mat Response Vehicle/Trailer☐ Emergency Back-up Generator (on location)☐ Command/Communications Vehicle**AGENCY BILLING:**

Does agency bill for service?

If yes, what year did agency begin billing?

Who is responsible for billing?

☐ Agency☐ Vendor

Does agency have a billing Subscription Service?

VACCINE ADMINISTRATION PROGRAM:

Do you have a vaccination program?

If Yes:

List Virginia Immunization Information System (VIIS) number:

PROGRAM ADMINISTRATION:

Authorized Prescriber

Vaccine Administrator:

Name:

Title:

(Last, First, Middle)

Mailing Address:

(Street Address)

(City, State, Zip Code)

Daytime Phone Number:

Evening Phone Number:

E-mail Address:

AGENCY REPRESENTATIVE/OWNER SIGNATURE:

Name:

(Please print name)

Date:

I hereby affirm that the information on this application is true and correct and I realize that any fraudulent entry may be considered sufficient cause for rejection of agency application, and/or enforcement action.

(Please sign name)

Date: